RFS#10-40
ATTACHMENT F
RESPONSIBILITIES OF THE STATE

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1.0 Activities of the State and Its Agents

Medicaid is a federal- and state-funded health care program providing payment for reasonable and medically-necessary care for persons meeting eligibility requirements. Each state administers its own program in accordance with federal requirements. In Indiana, the Indiana Family and Social Services Administration (FSSA), Office of Medicaid Policy and Planning (OMPP) administers the Medicaid program, which includes the Hoosier Healthwise and the Healthy Indiana Plan (HIP) programs. Other state agencies interface with OMPP in administering and managing the Hoosier Healthwise and HIP programs.

2.0 Medicaid Application and Eligibility Determination

Individuals will be able to apply for the Hoosier Healthwise and HIP programs through the Division of Family Resources (DFR) and other authorized enrollment centers. DFR is responsible for determining if persons are eligible for either program. DFR shall provide parents whose children apply for Hoosier Healthwise with information about HIP. DFR is also responsible for calculating POWER Account contribution and Hoosier Healthwise Package C (CHIP) premium amounts.

2.1 Eligibility Redetermination – Hoosier Healthwise

Hoosier Healthwise eligibility redetermination typically occurs every twelve (12) months.

2.2 Eligibility Redetermination – HIP

HIP eligibility redetermination will occur every 12 months.

2.3 Managing High-Risk Populations – HIP

This section applies to HIP only. In HIP, individuals with "high-risk conditions," as defined by OMPP, shall be assigned to the Enhanced Services Plan (ESP).

During the HIP application process, applicants shall be asked to complete a "general health questionnaire". This questionnaire shall be used to identify whether an individual has one or more of the high-risk conditions defined by OMPP. The general health questionnaire does not screen for all high-risk conditions defined by OMPP. Individuals may also be referred to the ESP based on the process described below.

For purposes of administration of the ESP, the following conditions are defined as high-risk conditions by OMPP.

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HIP High-Risk Conditions

Cancers*	
Bone	Leukemia
Brain and nervous system	Liver
Breast	Lung
Cervix/uterus	Multiple myeloma
Colon/rectum	Nasal sinus
Corpus uterus	Oral cavity, pharynx
Esophagus	Ovary
Eye	Pancreas
Gall bladder	Peritoneum
Hodgkin's lymphoma	Prostate
Non-Hodgkin's lymphoma	Sarcoma
Kidney, renal pelvis	Stomach
Larynx	Thyroid gland

*Cancers considered "distant" (spread to parts of the body remote from the primary tumor) are also considered a referable disease state whether or not present on this list. Also, in order to qualify for the ESP in the cancer category, the individual must have had cancer during the 3-year time period prior to the date of application for HIP.

AIDS	
Acquired Immune Deficiency Syndrome	Human Immunodeficiency Virus

Organ and Tissue Transplants	
Liver	Lung
Heart	Kidney
Bone marrow	

Aplastic Anemia	
Aplastic anemia – all types	

Hemophilia or Other Rare Bloodstream Diseases	
Hemophilia – Types A/B	Congenital factor VIII disorder
Christmas disease	Congenital factor IV disorder

Lipid Storage Diseases	
Tay Sach's Disease	Fabry's Disease
Nieman Pick Disease	

Primary Immune Deficiencies	
DiGeorge Syndrome	Wiskott Aldrich Syndrome
Combined Immune Deficiency	T cell deficiency

Diabetes with:	
Ketoacidotic coma	Retinopathy
Hyperosmolar coma	Peripheral vascular complications
Renal complications	Coronary Artery Disease

Other	
Muscular Dystrophy	Chronic Hepatitis B
Primary Pulmonary Hypertension	Hepatitis C
Amyotrophic Lateral Sclerosis	Cystic Fibrosis
Cirrhosis	ESRD/Renal Failure
CMV Retinitis	Paraplegia/Quadriplegia
Tuberculosis	Require frequent Blood Transfusions

An individual is eligible for the ESP if the applicant answered "yes" to any of the questions on the general health questionnaire identifying an ESP high-risk condition. These individuals shall remain enrolled in the ESP for their initial twelve (12)-month benefit period.

The ESP specializes in managing high-risk populations. The ESP provides the HIP benefit package, plus enhanced disease and case management.

During the redetermination process at the end of each benefit period, the State may assess an individual's claims experience to determine if the member should remain in the ESP or whether the individual shall be referred to a MCO for the subsequent benefit period. This process is described in further detail in the Managed Care Policies and Procedures Manual.

MCOs shall be given an opportunity to notify the State when they believe an individual enrolled in their plan belongs in the ESP. The HIP application process does not ascertain whether an individual has all ESP conditions. The application only screens for hepatitis, transplants, AIDS, aplastic anemia and hemophilia. Therefore, if the MCO can demonstrate that the individual meets specific criteria and obtains a minimum of "150 points" in **one** of the specific disease areas listed above, as outlined in the Milliman Underwriting Guidelines, the MCO may refer the member to the ESP. The referral must occur within one hundred and eighty (180) days after the individual's effective date or the date on which the MCO is notified of the individual's enrollment, whichever is later. Referrals may also occur after the redetermination process at the end of each benefit period. For example, after an individual's effective date, MCOs will have one hundred and eighty (180) days to transfer the individual into the ESP (even if the general health questionnaire did not indicate the existence of a high-risk condition during enrollment, so long as the member in fact has a high-risk condition). MCOs shall not transfer an individual to the ESP unless the individual meets the ESP criteria set forth by the State (at least "150 points" in **one** of the specific disease areas listed above, as defined by the Milliman Underwriting Guidelines). The MCO shall be required to use this criteria to make an ESP determination. MCOs shall be responsible for making referrals to the ESP and transferring POWER Account balances to the ESP as required under MCO transfer policies, which are set forth in the Managed Care Policies and Procedures Manual. In all cases, MCOs shall document that the criteria has been applied appropriately and must maintain a record of all documentation used to support the transfer. The State reserves the right to dispute any transfer by an MCO to the ESP.

MCOs shall be subject to an audit, at the State's expense, of their transfers to the ESP by the State and must cooperate fully with the State's auditor to provide all requested documentation.

The State will audit a minimum of ten percent (10%) of the referred cases. If the results of the audit indicate that inappropriate referrals have been made in greater than ten percent (10%) of the reviewed cases, the MCO shall be subject to liquidated damages as set forth in Attachment B to the Contract. In addition, the MCO shall be responsible for all claims costs, with the exception of pharmacy-related claims reimbursed by Indiana Medicaid FFS under the pharmacy benefit consolidation, incurred during enrollment in the ESP by any member deemed by the State's auditor to have been inappropriately referred to the ESP. Inappropriate referrals are defined as referrals to the ESP in cases where the member does not have "150 points" in **one** of the specific disease areas listed above, as defined by the Milliman Underwriting Guidelines. The State shall pay the MCO the applicable capitation rate, minus the administrative portion (for those months the member was enrolled in ESP), for each member deemed by the State's auditor to have been inappropriately referred to the ESP by the MCO.

MCOs are responsible for communicating with members being referred to the ESP to make sure that the member understands the transfer process and the rationale for the transfer to the ESP. MCOs shall notify members of the transfer by sending a letter informing them that they are being transferred to the ESP plan. The letter shall include ESP contact information for further questions. The MCO shall also conduct an outreach phone call to members to notify the member of the transfer and explain the benefits of the ESP. MCOs shall be required to document at least three (3) attempts to call members being transferred to the ESP. MCOs shall submit their education and outreach plans regarding ESP transfers to OMPP for approval.

If a MCO does not transfer a member to the ESP within one hundred and eighty (180) days after the member's coverage under the MCO's plan begins or the MCO is notified of the member's enrollment, whichever comes later, then the individual shall remain with the MCO for the rest of the benefit period. The next opportunity to transfer the individual to the ESP shall occur at the end of the benefit period. In these cases, the MCO shall request the transfer to the ESP prior to the end of the benefit period, in the form and manner prescribed by the State.

The State may refer an individual from the ESP back to the regular MCOs after the conclusion of a benefit period based on a review of the member's claims if, based on the claims review, it is determined that the individual does not have a high-risk condition. This process is described in further detail in the Managed Care Policies and Procedures Manual.

When a MCO makes an ESP determination and transfer, the MCO shall be responsible for transferring the POWER Account balance to the ESP and completing all necessary transfer requirements as established under MCO transfer policies, as well as maintenance of the individual's claims history, continued submission of encounter claims and payment of any claims incurred prior to the date of the transfer to the ESP. The State will not recoup the administrative portion of the capitation payments made to the MCO on behalf of the high-risk individual during the benefit period, and will reimburse the MCO for all claims paid by the MCO on behalf of the high-risk individual during the benefit period. Total reimbursement to the MCO for claims paid by the MCO on behalf of the high-risk individual during the benefit period shall be reduced by an amount equal to the capitation payments, minus the administrative portion, to be recouped by the State. The MCO shall submit a detailed invoice to the State within eighteen (18) months of the transfer and may only submit claims at one time for each referred individual. The MCO may only submit one invoice for each member, adjustments will not be made.

During the redetermination process at the end of each benefit period, enrollees in HIP shall be asked to fill out another general health questionnaire. If the general health questionnaire indicates

that the member developed a high-risk condition over the course of the previous benefit period, the State shall refer the member to the ESP and will provide the appropriate documentation.

3.0 Member Enrollment and Linkage to MCO

Applicants for both the Hoosier Healthwise and HIP programs will have an opportunity to select an MCO on their application. MCOs are expected to conduct marketing and outreach efforts to raise awareness of both the programs and their product. The Enrollment Broker is available to assist members in choosing an MCO. Applicants who do not select an MCO on their application will be auto-assigned according to the State's auto-assignment methodology.

The State's enrollment policies and procedures prohibit discriminating against individuals eligible to enroll on the basis of race, color, national origin, health status or the need for health care services, and the State will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, health status or the need for health care services, in accordance with 42 CFR 438.6(d). The MCO may neither terminate enrollment nor encourage a member to disenroll because of a member's health care needs or a change in a member's health care status, with the exception of permitted referrals of HIP members to the ESP. Further, a member's health care utilization patterns may not serve as the basis for disenrollment from the MCO. MCOs must not discriminate against individuals eligible to enroll on the basis of race, color, national origin, ancestry, disability, age, sex or religion and must not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, disability, age, sex or religion.

3.1 Enrollment Broker Services

The State's Enrollment Broker employs Benefit Advocates (BAs) who present managed care information to potential members. The BAs educate potential members about the benefits of primary and preventive care, the differences between the MCO options available to the potential member and the importance of choosing a PMP once enrolled in an MCO and establishing the PMP and member relationship.

BAs also provide members with a description of the MCO options and participating providers available with each MCO. The BAs facilitate the enrollment process with informative brochures and MCO promotional information as part of the enrollment process. During the enrollment process, the BAs are available to provide information to potential members about:

- The usefulness of primary and preventive care
- The differences between the MCOs available
- The PMPs and other providers available with each MCO within a 30-mile radius of the member's residence
- The importance of choosing an MCO
- The importance of having a PMP and the opportunity to select a PMP after enrolling in a MCO

3.2 Auto-assignment to MCO

For Hoosier Healthwise and HIP eligibles who do not select an MCO on the application, the State fiscal agent will auto-assign the individual to an MCO. The rules and logic for auto-assignment are created by the State and comply with 42 CFR 438.52(f).

The State maintains eligibility records in ICES, the State's management information database. The State transmits eligibility data daily to Indiana*AIM*. The Indiana*AIM* system identifies Hoosier Healthwise and HIP eligibles who did not select an MCO on their application and auto-assigns them to an MCO according to the State's auto-assignment methodology.

The State reserves the right to amend the auto-assignment logic and may incorporate HEDIS or other quality indicators into the auto-assignment logic at a future date.

3.3 POWER Account Contributions and CHIP Premiums

After an individual to MCO linkage occurs, either by self-selection or auto-assignment, individuals eligible for HIP and Hoosier Healthwise Package C (CHIP) must pay their initial POWER Account contribution or Hoosier Healthwise Package C (CHIP) premium, as applicable, before enrollment in the MCO is final.

3.4 Enrollment of Newborns – Hoosier Healthwise

Babies born to Package A or B women are automatically eligible for Medicaid benefits for one year from the baby's date of birth.

If the woman is enrolled in an MCO on the newborn's date of birth, the baby is assigned to the woman's MCO, retroactive to the baby's date of birth, assuming the availability of an appropriate PMP for the newborn. The MCO will receive the newborn's monthly capitation rate retroactively from the newborn's date of birth once eligibility for the newborn is established and the baby is enrolled in the MCO. The State fiscal agent will notify the mother in writing of the auto-assignment of the newborn.

If the newborn is not assigned to the mother's MCO due to the lack of pediatric panels slots in the mother's MCO, the newborn will remain in fee-for-service until the effective date of an assignment to another MCO. In these cases, claims for services from the baby's date of birth until assignment to an MCO will be the responsibility of the State fiscal agent on a fee-for-service basis.

The Hoosier Healthwise program encourages pregnant women, whether in Package A or B, to select a PMP for their child prior to the birth of their baby. A mother must choose a PMP for her unborn child from the MCO in which she is enrolled.

Newborns of women in Package C are not automatically eligible for the benefits. If a woman who is enrolled in Package C becomes pregnant, she must submit a CHIP application for her newborn. The State must determine if the newborn is eligible for the CHIP program, and the member must pay the Hoosier Healthwise Package C (CHIP) premium before the newborn is enrolled in the program. Once the State receives the first Hoosier Healthwise Package C (CHIP) premium payment, the newborn is eligible for benefits. The State will assign the newborn prospectively to an MCO either by selection or auto-assignment.

The Managed Care Policies and Procedures Manual provides more information regarding the Pre-Birth Selection and MCO selection and change process.

4.0 Enrollment Rosters

The State fiscal agent notifies each MCO of all members enrolled in the MCO.

The State fiscal agent generates MCO Member Enrollment Rosters using information obtained from the DFR's ICES transmissions, and MCO assignments entered into the Indiana*AIM* system. The MCO Member Enrollment Rosters provide the MCO with a detailed listing of all members for whom the MCO is or has been responsible and identifies each enrollee's benefit package if the member is in Hoosier Healthwise (i.e., Package A, B, C or P). The enrollment roster also identifies deleted enrollees who appeared as eligible members on the previous roster, but whose eligibility terminated prior to the actual effective date with the MCO.

The MCO is responsible for reconciling the eligibility rosters with capitation payments received and, for HIP members, the State's POWER Account contributions. If an MCO receives either eligibility information or capitation for a member, and/or the State's POWER Account contribution for a HIP member, the MCO is financially responsible for the member. The State fiscal agent's eligibility verification systems, which are updated daily, must be used in the event of any discrepancies. The MCO discovering eligibility/capitation/POWER Account contribution discrepancies shall notify the fiscal agent within thirty (30) calendar days of discovering the discrepancy and no more than ninety (90) calendar days after the MCO receives the eligibility records.

Refer to the Managed Care Policies and Procedures Manual for detail about the eligibility roster process.

5.0 MCO Member Enrollment Limitations

To ensure member choice of MCOs and availability of PMPs, on a county-by-county basis, the State will monitor MCO member enrollment in the region monthly. The State reserves the right to monitor the actual panel sizes of each of the MCO's PMPs. If the determination is made to restrict an MCO's enrollment, the State will notify the MCO in advance of implementing member enrollment limitations. The State may impede MCO member enrollment growth by one or more of the following methods:

- Excluding the MCO from receiving default auto-assignment
- Excluding the MCO from receiving previous MCO auto-assignment

The State will evaluate MCO member enrollment each month to determine when any of the member limitations may be lifted.

6.0 Member Disenrollment from the MCO

6.1 Twelve (12)-Month Member Lock-In

Members will be locked into an MCO for a period of twelve (12) months. However, 42 CFR 438.56 permits members to request disenrollment from the MCO for just cause at any time.

6.2 Changing MCOs

6.2.1 Changing MCOs for Just Cause

In both Hoosier Healthwise and HIP, members may change MCOs at any time for just cause. Members must file a grievance with their MCO before a determination will be made upon their just cause request. See the Managed Care Policies and Procedures Manual for further detail.

If a HIP member changes MCOs, the MCO must disable the member's POWER Account debit card immediately.

6.2.2 Changing MCOs Without Cause – Hoosier Healthwise

Hoosier Healthwise members are allowed to change MCOs during the ninety (90)-day period following their initial enrollment with the MCO, as well as every twelve (12) months thereafter. The member can disenroll from the MCO by contacting the Enrollment Broker and requesting a change in his/her MCO assignment.

6.2.3 Changing MCOs Without Cause – HIP

HIP eligibles have a right to change MCOs within sixty (60) days of their initial enrollment in the MCO or before their first POWER Account contribution is made, whichever comes first. The MCO must notify HIP eligibles in the Welcome Letter of their right to change MCOs within sixty (60) days of their initial enrollment in the MCO or before making the first POWER Account contribution, whichever comes first.

At the end of each twelve (12)-month benefit period, HIP members will also have an opportunity to change MCOs. Members will also be given an opportunity to change MCOs when the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(3).

If a HIP member changes MCOs, the MCO must disable the member's POWER Account debit card immediately.

7.0 Disenrollment from the Programs

7.1 Disenrollment from Hoosier Healthwise

The following are causes for which Hoosier Healthwise members can be disenrolled from the Hoosier Healthwise program:

- The member was enrolled in error or because of a data entry error.
- The member loses eligibility in Hoosier Healthwise.

An MCO member may disenroll from an MCO while retaining eligibility in the Hoosier Healthwise program. Member disenrollment from an MCO with enrollment into another MCO occurs under any of the following circumstances:

- The member selects a PMP in another MCO during their ninety (90) day free change period.

- The member's PMP disenrolls from the MCO and is available to Hoosier Healthwise members in another MCO.
- The disenrollment is approved by OMPP because of circumstances which, in the judgment of the OMPP, are documented and justified.

Some instances may warrant a member's disenrollment from the Hoosier Healthwise managed care program while eligibility is maintained in another Indiana Health Coverage Programs (IHCP) component. It is important to the program's integrity that criteria used to make this determination are valid reasons for disenrollment and are applied consistently for all program enrollees. The Enrollment Broker monitors, tracks and approves all member disenrollment based on the program's policy for quality improvement. OMPP has the ultimate authority for allowing eligible members to disenroll from the program. Examples of acceptable reasons for member disenrollment from the Hoosier Healthwise managed care program to participate in another IHCP program include but are not limited to the following:

- The member is determined to be ineligible for managed care under the terms of the State of Indiana 1915(b) waiver.
- A change in aid category causes the enrolled member to become ineligible for managed care.
- The enrolled member meets long-term care (LTC) criteria, determined by Indiana Pre-Admission Screening and the Federal Pre-Admission Screening (IPAS/PASRR).

MCOs may not request disenrollment of a member because of an adverse change in the member's health status; the member's utilization of medical services; diminished mental capacity; uncooperative or disruptive behavior resulting from the member's special needs (except when the member's continued enrollment in the MCO seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

OMPP has the ultimate authority for allowing eligible members to disenroll from the program. OMPP and the Enrollment Broker discourage members from disenrolling and switching programs frequently. In accordance with 42 CFR 438.56(d)(3), the disenrollment will automatically be considered approved within the timeframe stated in the federal regulation. For more information regarding the procedures for member disenrollment, refer to the Managed Care Policies and Procedures Manual.

If premium payments are delinquent, OMPP will disenroll a child from Package C after a sixty (60)-calendar day grace period. However, upon payment of any delinquent premiums from the past twenty-four (24) months, OMPP will reinstate the child and re-assign the child to his/her previous MCO (if appropriate). If reassignment to the child's previous MCO is not appropriate, the child will be auto-assigned to an appropriate MCO. The State pays providers' claims during the Package C member's retro-eligibility period through the FFS delivery system.

7.2 Disenrollment from HIP

Members will be disenrolled from HIP for any one of the following reasons:

- The member fails to make the required monthly POWER Account contribution within sixty (60) calendar days of its due date

- The member is determined ineligible for HIP at redetermination
- The member obtains access to employer sponsored coverage
- The member becomes covered under another health insurance program or Medicaid program
- Any other reason set forth in 405 IAC 9-4-5

If a member is disenrolled from HIP, the MCO must disable the member's POWER Account debit card immediately.

8.0 Provider Enrollment and Disenrollment

The State considers all providers as eligible to participate in Hoosier Healthwise and HIP when the provider enrolls with the IHCP. All Hoosier Healthwise and HIP providers must first be enrolled as IHCP providers before providing services to members. The State allows physicians to contract as PMPs, specialists and ancillary providers in any number of MCOs.

9.0 Ongoing MCO Monitoring

OMPP reviews and monitors MCO performance on a regular basis and identifies non-compliance with program requirements and performance standards outlined in the Contract, the Scope of Work and all attachments. OMPP conducts monitoring activities through site visits, document review, review of performance data and analysis of encounter claims data. OMPP reserves the right to change or modify the reporting requirements, evaluation instruments and enforcement policies, as necessary, at any time during the Contract period with sufficient notice to the MCOs resulting from its monitoring activities or changes in state or federal requirements.

OMPP, or duly authorized agents of the state or federal government, reserves the right to inspect, audit, monitor or otherwise evaluate the performance of the MCO or its subcontractors during normal business hours, at the MCO's or its subcontractors' premises. At a minimum, OMPP will conduct regular monthly on-site reviews, and these reviews may include an audit of financial or operational systems and data.

In addition, OMPP complies with the external quality review regulations for monitoring managed care organizations set forth in 42 CFR 438.350.

9.1 Evaluating MCO Solvency

The Indiana Department of Insurance maintains the primary responsibility for monitoring the MCO's solvency and monitors the MCO's financial status.

In addition, OMPP monitors the MCO's solvency status in accordance with federal regulations described in 42 CFR 438.116 by requiring the submission of various financial data for review.

10.0 Making Payments to the MCO

OMPP pays MCOs participating in Hoosier Healthwise and HIP a monthly capitation payment for each enrolled member. For Hoosier Healthwise members, OMPP also, upon submission of

proper encounter claims data, makes an additional payment for maternity deliveries. For HIP members, OMPP makes the State's POWER Account contribution payment ~~and, for Non-Caretaker Relatives in Year One of the Contract, a stop loss payment~~. The Managed Care Policies and Procedures Manual discusses the capitation payment process, Electronic Funds Transfer (EFT) and other related issues.